King County

Date received by department contact

Protected Family and Medical Leave Request Form

Instructions

- The employee must submit this form 30 calendar days before leave begins (if the leave is foreseeable) or as soon as possible (if the leave is unforeseeable), and return this form to your department human resources contact or designee.
- A medical certification form is required for each requested leave of absence and must be submitted within 15 calendar days of request.
- For additional information, please visit http://www.kingcounty.gov/employees/benefits/LeaveAdministration.aspx or see your human resources manager/supervisor for paper versions of these materials.

To be completed by the employee

Employee Name _____ Phone _____ Email _____

Home Address _____ City _____ State _____ Zip _____

Employee ID# _____ Supervisor Name _____ Work location _____

If your spouse/domestic partner works for King County, provide his/her name and department _____

Leave is to care for

☐ Self ☐ Other Please provide name and relationship:_____

Reason for leave – please do not provide detailed medical information

_____

Leave schedule

Leave start date (first workday unable to work regular schedule) _____ Anticipated return-to-work date _____

Briefly describe how leave will be taken (e.g., full-time for four weeks, full-time for one week and then intermittent for two weeks, etc.):

_____

Paid leave accruals – check all that apply

Leave for my own serious health condition:

After my sick leave is exhausted, I elect to use my paid leave in the following order (indicate with 1, 2, 3 and 4):

Vacation leave _____ Compensatory time _____ Executive leave _____ Other (describe _____) _____

Leave to care for family member:

I elect to use my paid leave in the following order (indicate with 1, 2, 3, 4, 5 and 6):

Sick leave ___ Vacation leave ___ Compensatory time ___ Executive leave ___ LWOP ___ Other type (describe _____) ___

☐ I elect to reserve _____ hours of my sick leave for later use (the maximum is 80 hours).

☐ I elect to take this leave without pay by immediately going into an unpaid status.

Employee acknowledgement of request – read carefully

The information I have provided is true, correct and complete. I understand that if I have falsified any information related to my Protected Family and Medical Leave Request, it may lead to disciplinary action up to and including discharge from employment. I understand that I am required to follow the usual and customary procedure for calling in. I will notify my supervisor and/or department human resources contact or designee if and when there are changes to the circumstances of my leave and provide updated medical certification as required. I understand that my supervisor or department human resources contact or designee may contact me during my leave period to verify my status and obtain updates as to my estimated date of return to work. I understand that for me to return to work from my own serious health condition, my health care provider may need to provide a release for return to full-time, part-time or transitional duty and that any release other than a full release must be reviewed and approved by my supervisor and/or department human resources contact or designee before I report to work.

Employee signature _____ **Date** _____

Medical Certification form: ☐ Attached ☐ Not attached, but will be provided ☐ Documentation attached for baby/child bonding